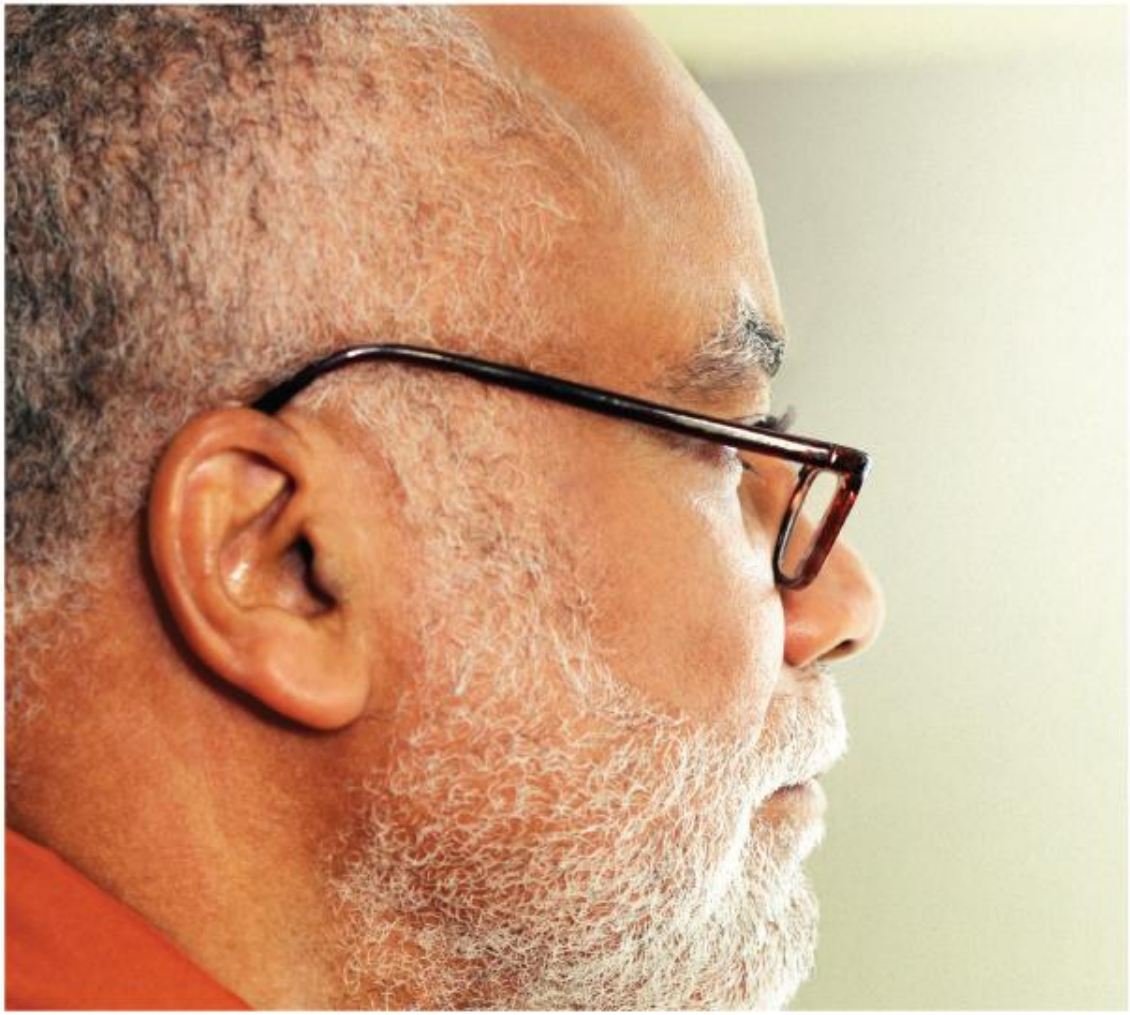

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Health Home Forums

October 2012

Purpose:

*Overview of integration & health homes

*Describe how health homes work

*Facilitate collaborations among potential partners for health home networks

Agenda

- Overview of Integration and Health Homes Strategy
- Update on Health Home planning and implementation
- Discuss Essential Requirements and Rates
- Breakout sessions with potential Health Home entities, Care Coordination Organizations and partners
- Discuss approaches and concerns

Integrated Care Vision

Systems must:

- Be based in organizations that are accountable for costs and outcomes
- Be delivered by teams that coordinate medical, behavioral, and long-term services
- Be provided by networks capable of meeting the full range of needs
- Emphasize primary care and home and community based service approaches

Integrated Care Vision

Systems must:

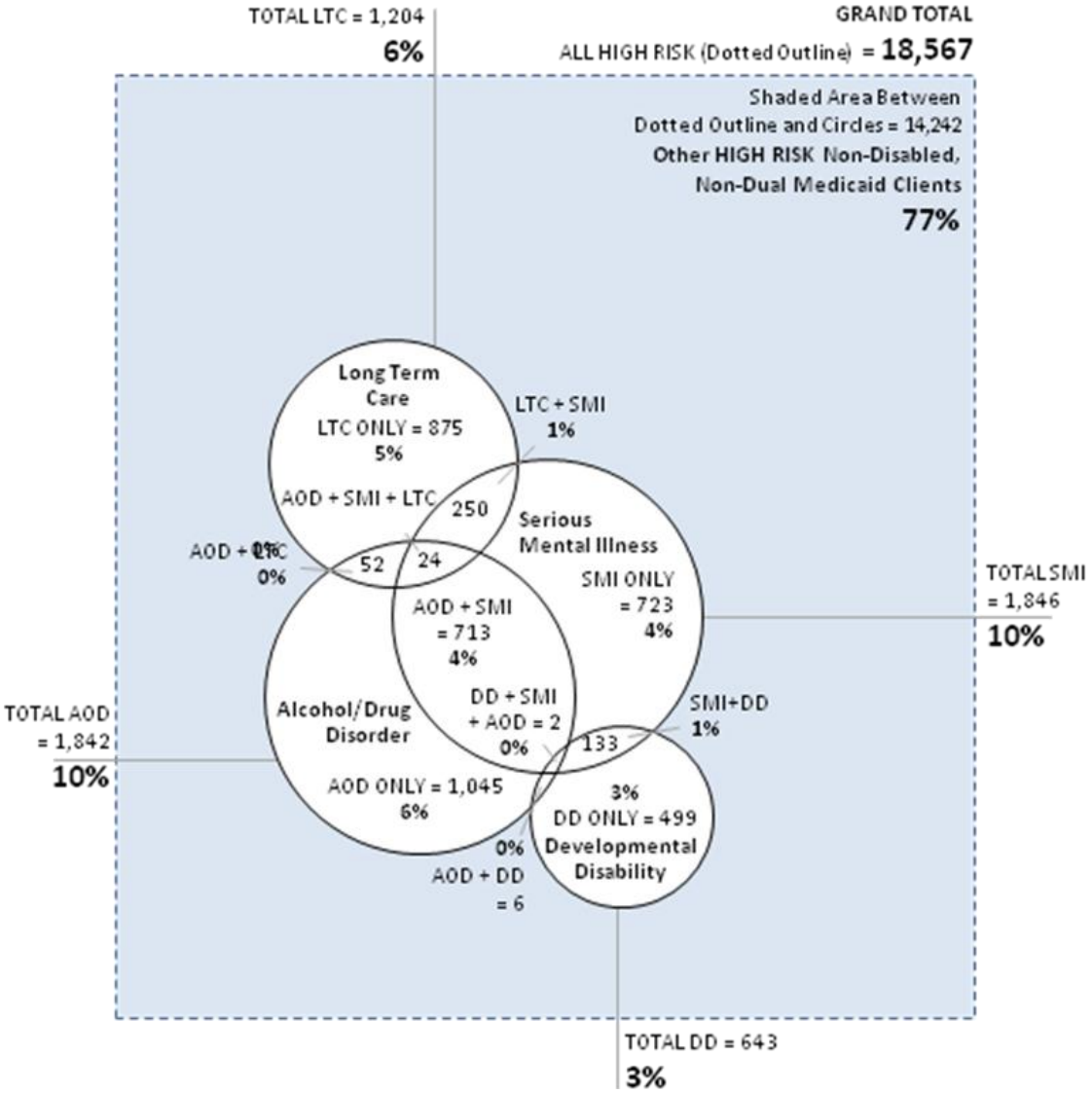
- Provide strong consumer protections that ensure access to qualified providers
- Respect consumer choices in the supports they receive
- Unite consumers and providers in eliminating use of unnecessary care
- Align financial incentives to impel integration of care

Drivers for Integration

- Fragmented service delivery and lack of overall accountability (medical and non-medical)
- Service needs and risk factors overlap in high-risk populations
- Incentives not aligned to achieve outcomes
- Sustainability concerns
- High-risk populations
- Federal and state legislative direction

Service need and risk factor overlaps among high risk Healthy Options

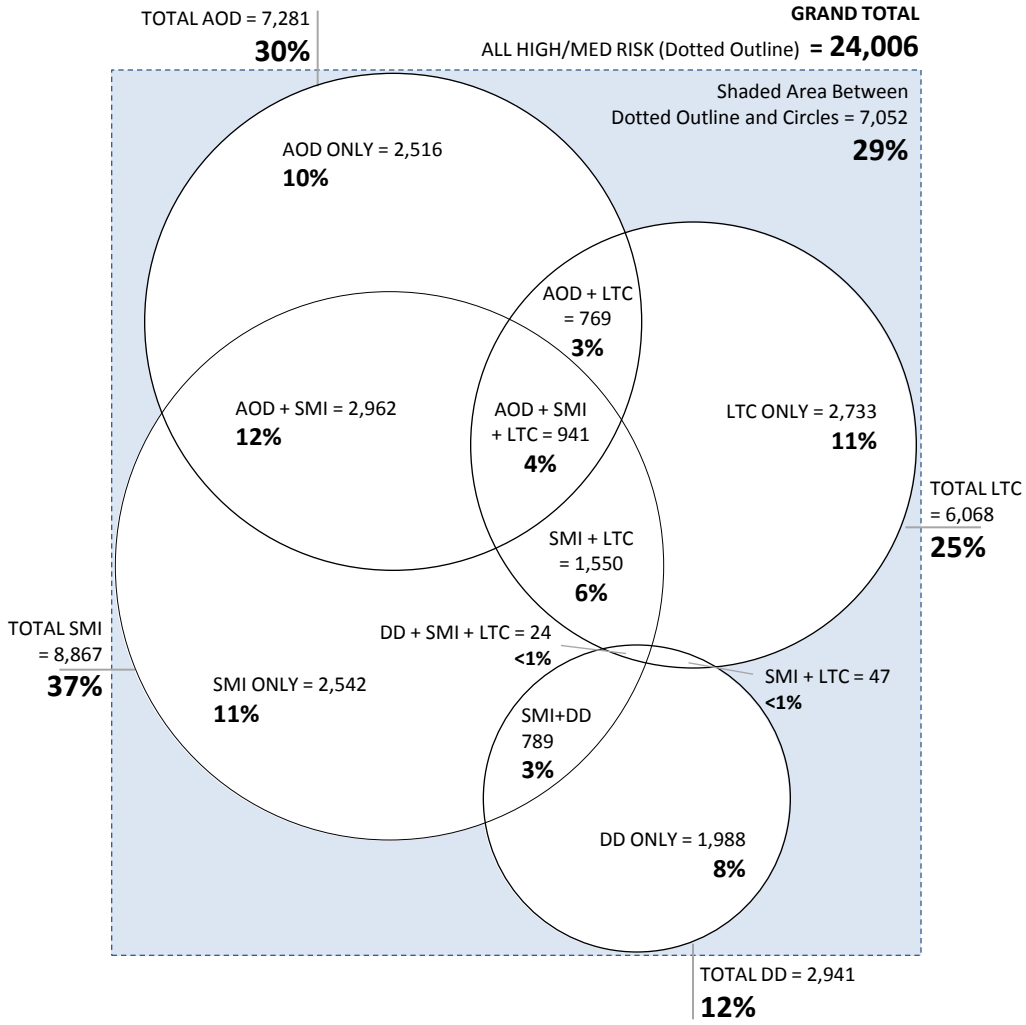
State Fiscal Year 2009



SOURCE: DSHS Research and Data Analysis Division, Integrated Client Database, January 2012.

Service need and risk factor overlaps among high medical need Medicaid Only Disabled clients

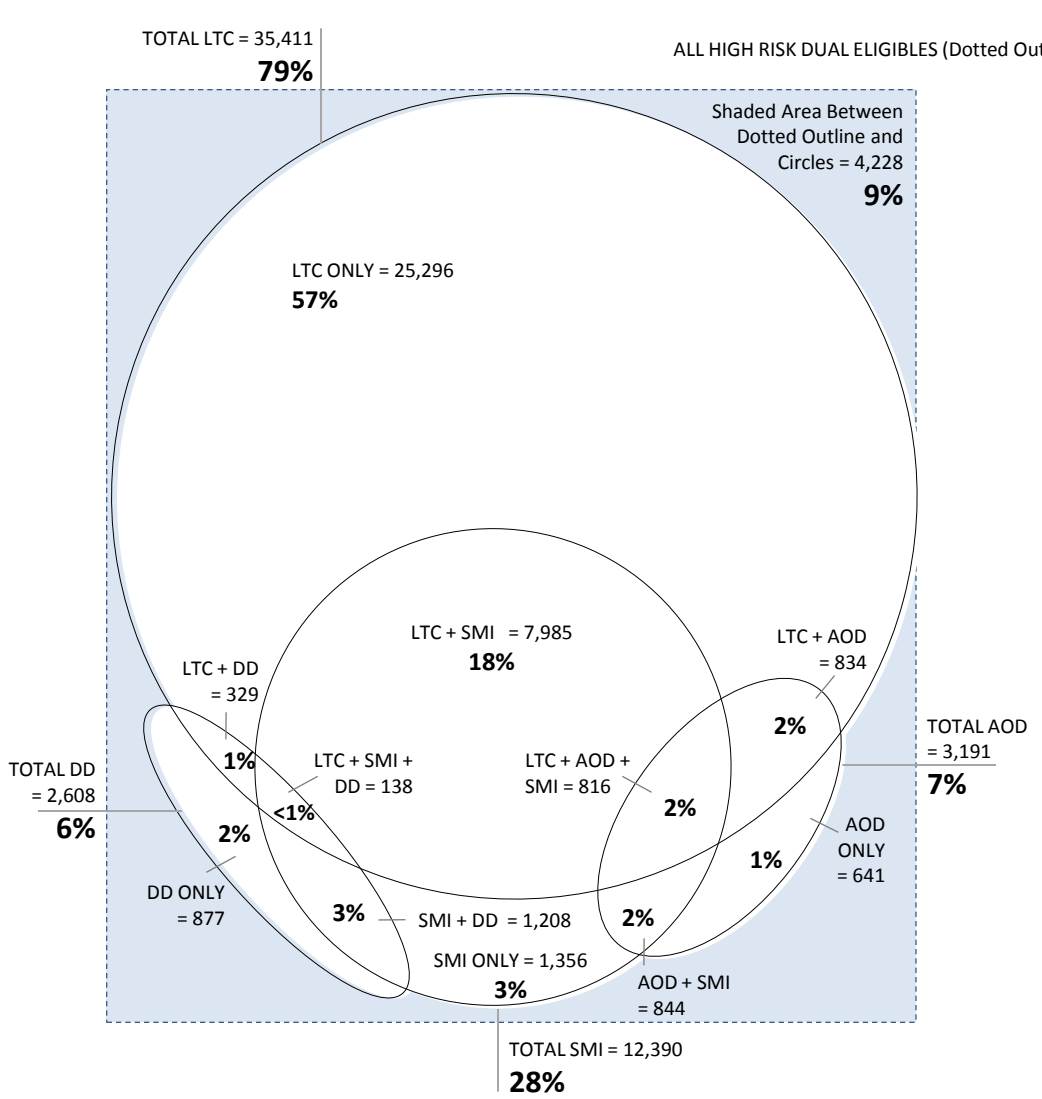
STATE FISCAL YEAR 2009



SOURCE: DSHS Research and Data Analysis Division, Integrated Client Database, January 2012.

Service need and risk factor overlaps among high risk DUAL ELIGIBLE Aged or Disabled clients

STATE FISCAL YEAR 2009



SOURCE: DSHS Research and Data Analysis Division, Integrated Client Database, January 2012.

Strategy for Integrating Care

- Embed robust delivery of health home services in all systems
- Act as a bridge to coordinate across all systems of care
- Integrate service delivery at the local community level where beneficiaries receive health care and social services
- Recognition that health and social services are inter-related

Sources that Inform WA's Health Home Model

- Federal law – Section 2703, Affordable Care Act
- State law – SSB 5394 (passed in 2011)
- Stakeholder feedback during "Duals" planning
  - Integrate across medical and social services to improve coordination and align incentives
  - Create a single point of contact and intentional care coordination for beneficiaries
  - Build on what's working while improving, including flexibility to allow for local variances based on population need and provider networks

Health Home Services

Federal Affordable Care Act Section 2703

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support Services
- The use of HIT to Link Services

Health Homes Services: The Washington Way

- A new set of services targeted to high cost/high risk clients who could benefit from intensive care coordination
- Will not duplicate or take the place of other case management services provided through Medicaid
- Focus on working with beneficiary on personal health action goals

Health Homes Services: The Washington Way (cont.)

- Make changes to improve beneficiaries' ability to function in their home and community and their self-care abilities;
- Slow the progression of disease and disability;
- Access the right care, at the right time and place;
- Successfully transition from hospital to other care settings and get necessary follow-up care;

Health Homes Services: The Washington Way (cont.)

- Reduce avoidable health care costs; and
- Ensure access to after hours assistance to help with health care decisions during evenings or weekends when the Health Home coordinator is not available

A Health Home Provides Integrated Care For:

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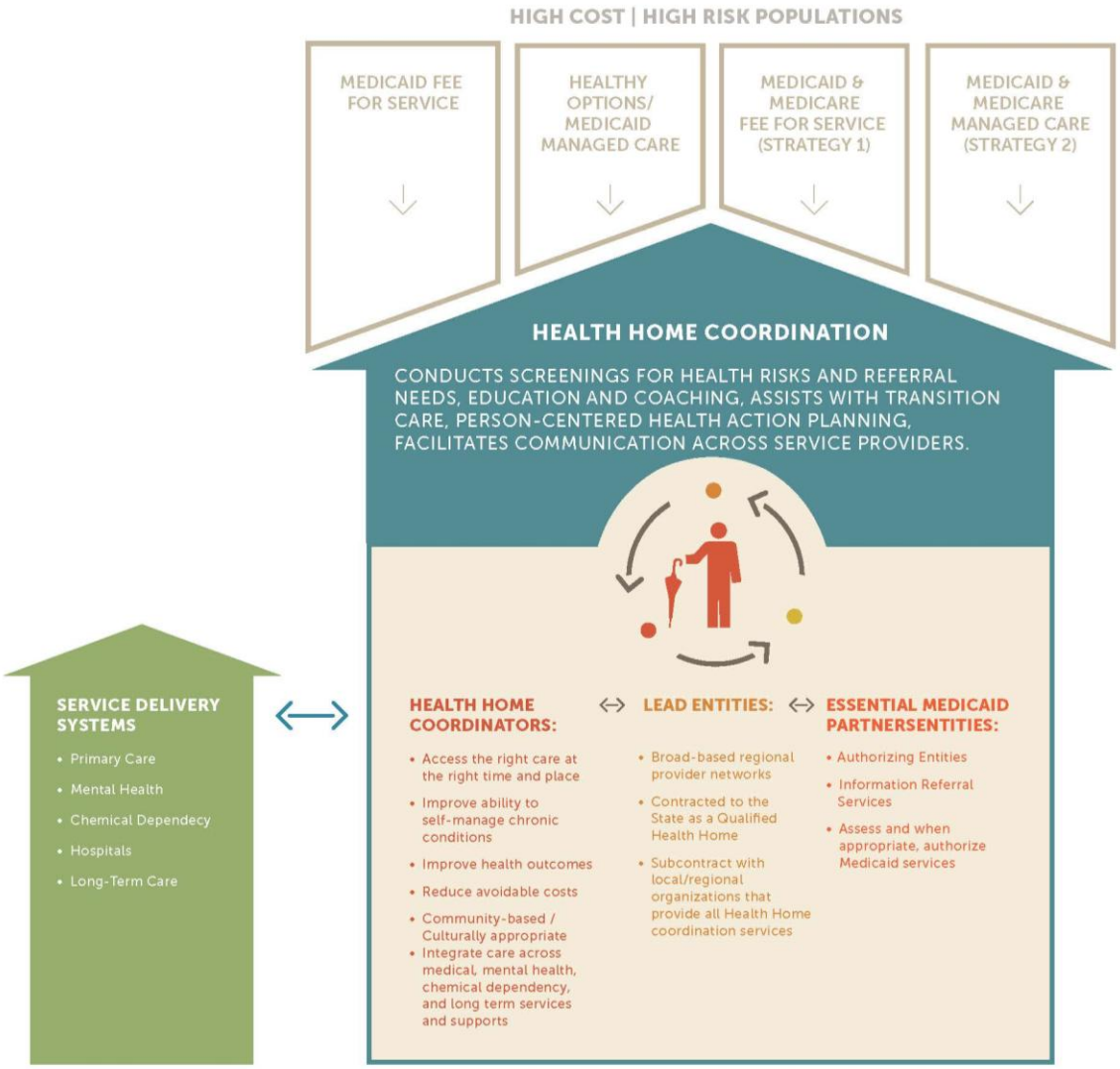

After Health Home

My Health Home Coordinator
Lead Entity

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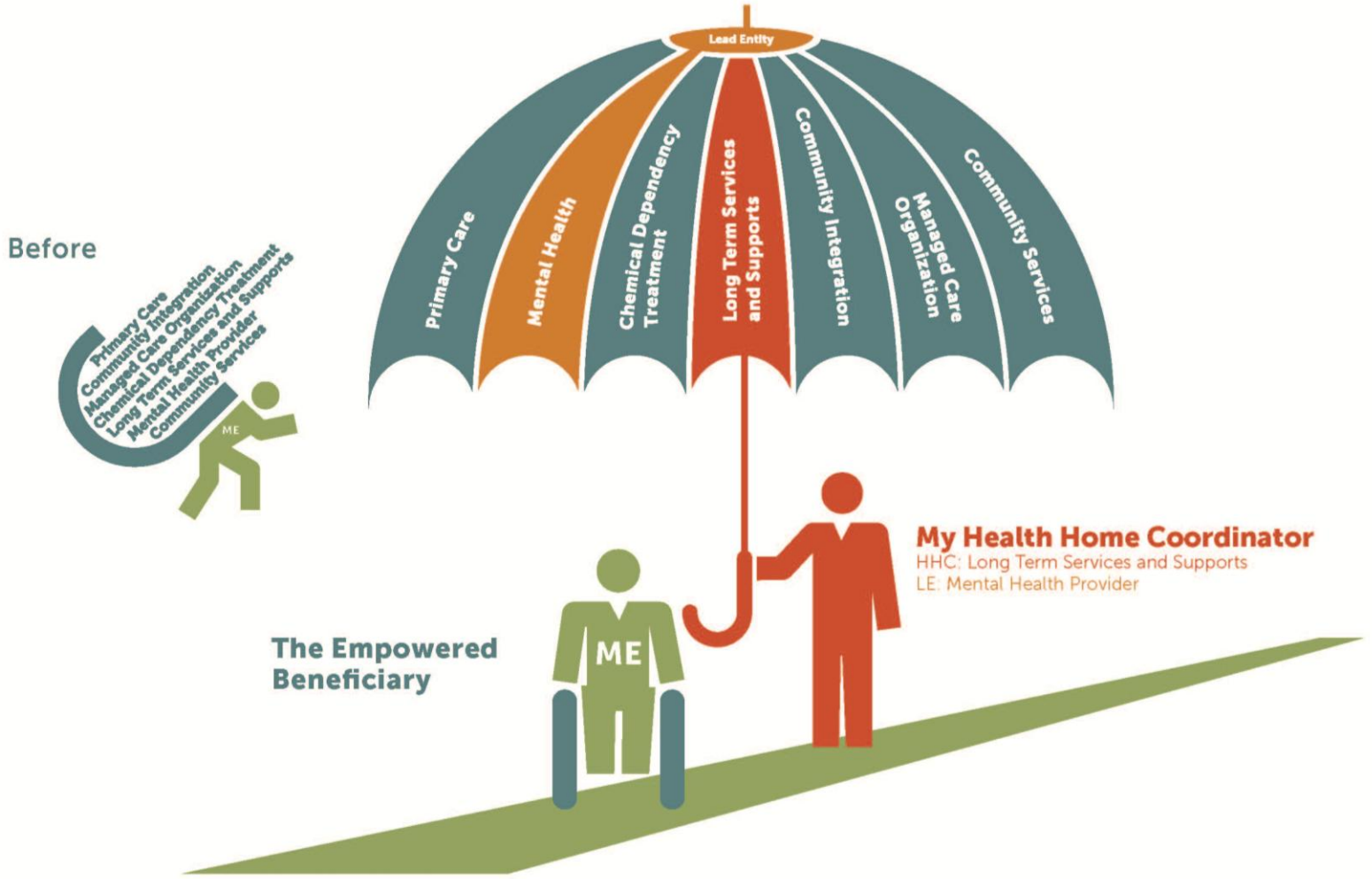

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Coordination and Integration Create A Better Care Experience for the Beneficiary

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Washington State Health Care Authority

Washington State Department of Social & Health Services

Essential Requirements

- Refer to Essential Requirements Document
  - lays out who is responsible for what
- Role of Lead Entity
- Role of CCOs and HH Coordinators

Health Homes Coverage Areas

- Seven health home network coverage areas
- Development of coverage areas takes into consideration:
  - Integration at the local service delivery level
  - Diversity in the types of care coordination entities needed to serve the population
  - Financial sustainability
  - Oversight
  - Fidelity
  - Administrative simplification

Health Home Network Coverage Areas

Effective October 8, 2012

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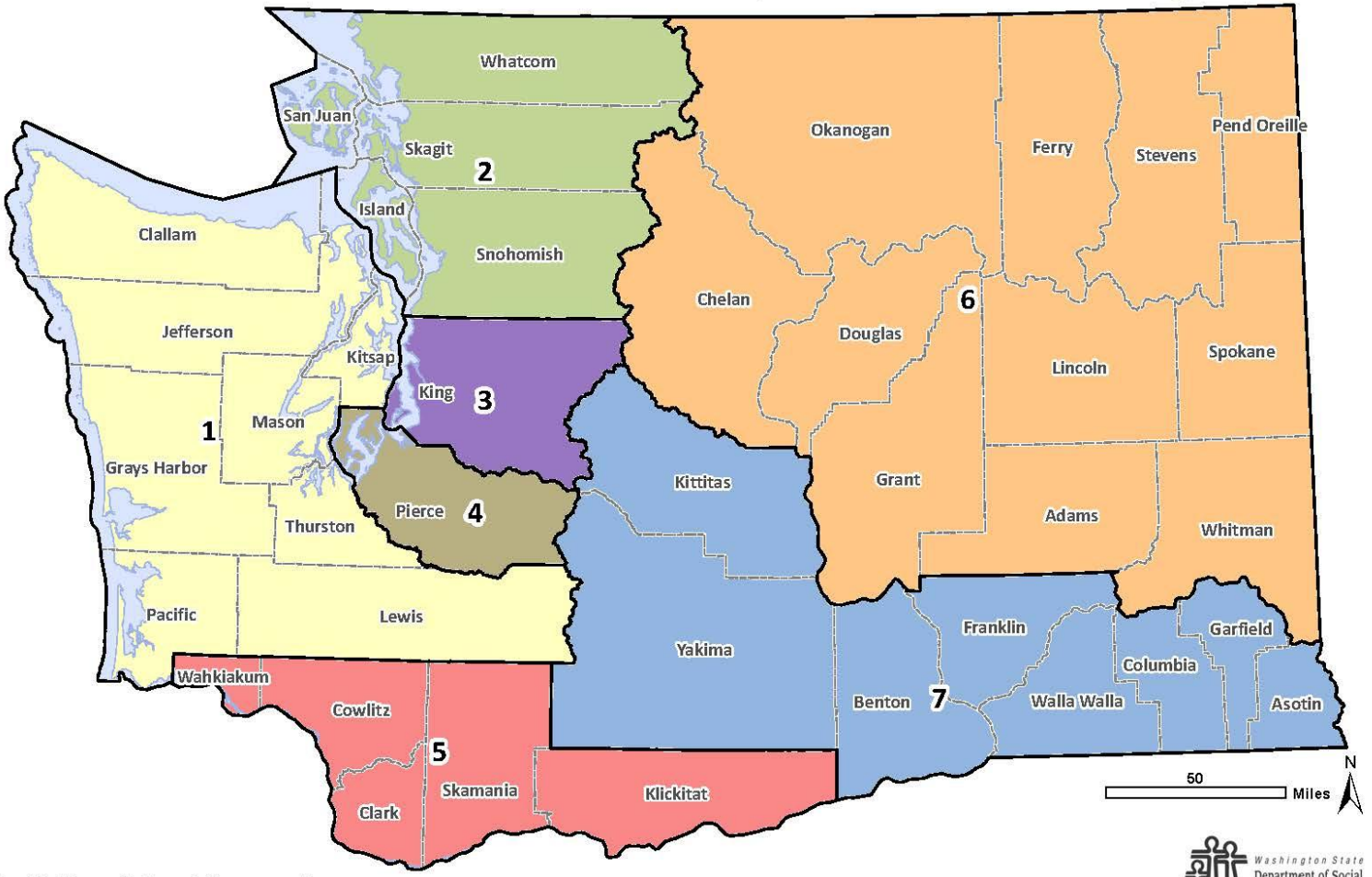

Health Home Network Coverage Areas

1 2 3 4 5 6 7 County boundary

Sources: Health Home Network Coverage Areas: Health Care Authority, DSHS Aging and Disability Services Administration. Counties: 2010 TIGER/Line shapefile.

Washington State Department of Social & Health Services

RDA Research & Data Analysis Division

Map Created: October 11, 2012

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Washington State Health Care Authority

Washington State Department of Social & Health Services

Coverage Area Relationships

- Lead entity based on coverage area
- Can be more than one lead entity serving each coverage area and state will limit the number of qualified networks
- Lead entity contracts with CCOs that serve beneficiaries
- CCOs can contract with more than one lead entity

Target Populations

- Health homes will be available to high cost/high risk populations statewide
- The state will not implement health homes using ACA Section 2703 funding (Strategy 1) during the duals demonstration period in geographic areas where the financial capitation model (Strategy 2) is implemented

Health Home Rates

- Rates paid to lead entity - administering entity
- Lead entity pays contracted CCOs
- Payment only occurs in months where a qualified service is provided
- Only one payment is made per month
- Quality withhold paid based upon meeting or exceeding quality benchmarks

Three Payment Tiers

Tier	Administrative Portion	Care Coordination Portion	Quality Withhold
Outreach, engagement & Health Action Plan Execution*	$25.27	$227.64	$0
High Intensity	$13.81	$155.35	$3.45
Low Intensity	$5.40	$59.40	$1.35

Please refer to October 11, 2012 correspondence from Milliman to Becky McAninch-Dake.

Health Home Outcomes

- Reduce non-emergency emergency room use
- Reduce ambulatory sensitive hospital admissions and all-cause readmissions
- Increase screening & follow-up
- Increase beneficiary activation levels

Next Steps

- Health Home Network Forums Oct. 16-31
  - Intent is to facilitate collaborations among potential partners for health home networks
- Release application based on roll-out
- Continue to work on State Plan Amendment and MOU with Center for Medicare & Medicaid Services

Draft Roll-Out Schedule

Release	A	B	C	D
Coverage Area	4 & 7	6	1 & 5	2 & 3
App Release Date	11/9/2012	1/11/2013	3/11/2013	5/13/2013
Apps due	12/14/2012	2/08/2013	4/08/2013	6/11/2013
Contract Start Date	4/1/2013	7/01/2013	09/01/2013	11/01/2013

Resources

Websites:
http://www.hca.wa.gov/health_homes.html
http://www.integratedcareresourcecenter.com/

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Questions & Answers